DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

RE EWED

(X2) MULTIPLE CONSTRUCTACH 2 0 2010

PRINTED: 07/28/2010 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	OFFICE OF INSPECTOR GENERAL	COMPL	ETED
		185178	B. WIN	G	DIVISION OF HEAVEN CARE EXCLUSION AND SERVICE	07/1	15/2010
	ROVIDER OR SUPPLIER DPHER EAST HEALTH	I CARE CENTER		4200	ADDRESS, CITY, STATE, ZIP CODE BROWNS LANE ISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 156 SS=E	and concluded on 0 cited with the higher "E". A Life Safety Concluded on 07/15 not to meet the minicode of the Federa The highest scope a identified was an "F 483.10(b)(5) - (10), RIGHTS, RULES, Some substituting in a launderstands of his conclude (if any) of the §1919(e)(6) of the Amade prior to or upon and in writing in a launderstands of his conclude (if any) of the §1919(e)(6) of the Amade prior to or upon and amendments to writing. The facility must informative to Medicaid of admission to the inferited to Medicaid of admis	vas conducted on 07/13/10 7/15/10. Deficiencies were est scope and severity of an code survey was initiated and /10. The facility was found imal requirements with 42 I Regulations, Part 483.70. and severity deficiency 1. 483.10(b)(1) NOTICE OF EERVICES, CHARGES orm the resident both orally inguage that the resident or her rights and all rules and ing the stay in the facility. The ovide the resident with the State developed under incit. Such notification must be on admission and during the representation of such information, and it, must be acknowledged in orm each resident who is benefits, in writing, at the time increase facility or, when the igible for Medicaid of the hat are included in nursing or the State plan and for may not be charged; those rices that the facility offers sident may be charged, and when changes are made to es specified in paragraphs (5)	F 0	To code all Teach that the form in F It the action of the control	the statements made on this plant or prection are not an admission to not constitute an agreement will leged deficiencies herein. The remain in compliance with all and state regulations, the center ken or will take the actions set the following plan of correction controllowing plan of correction	o and with the lifederal has forth in The stitutes ance. We been or dates o inform riting in erstands and onduct tay in so tice (if a under to or	(X6) PATE
	Helbul 11	allans)	C	X	/ Admenistrator	\propto	\$17/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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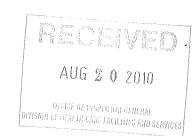
	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		185178	B. WI	NG _		07/1	5/2010	
	F PROVIDER OR SUPPLIER TOPHER EAST HEALT	H CARE CENTER		4	REET ADDRESS, CITY, STATE, ZIP CODE 1200 BROWNS LANE LOUISVILLE, KY 40220			
(X4) II PREFI TAG	((EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 15	The facility must infat the time of admis the resident's stay, facility and of chargincluding any chargunder Medicare or The facility must fur legal rights which in A description of the personal funds, und section; A description of the for establishing eligithe right to request 1924(c) which deternon-exempt resourcinstitutionalization a spouse an equitable cannot be considered toward the cost of the medical care in his down to Medicaid elements of all pertingroups such as the agency, the State licombudsman programadvocacy network, a unit; and a statemer complaint with the Sagency concerning misappropriation of	form each resident before, or sion, and periodically during of services available in the es for those services, es for services not covered by the facility's per diem rate. Thish a written description of cludes: manner of protecting der paragraph (c) of this requirements and procedures dibility for Medicaid, including an assessment under section ratines the extent of a couple's ces at the time of a dattributes to the community eshare of resources which ed available for payment the institutionalized spouse's for her process of spending digibility levels. Addresses, and telephone then State client advocacy State survey and certification censure office, the State m, the protection and and the Medicaid fraud control at that the resident may file a state survey and certification resident abuse, neglect, and resident property in the appliance with the advance	F	156	It is the practice of this facility each resident who is entitled to Medicaid benefits, in writing, a of admission to the nursing facility when the resident becomes elig Medicaid of the items and serviare included in nursing facility under the State plan and for which the resident may not be charged'th items and services that the faciliand for which the resident may charged, and the amount of chathose services' and inform each when changes are made to the is services specified in paragraphs (5)(i)(A) and (B) of this section. The facility will continue to inform the facility and of charges for the facility and of charges for the services, including any charges services not covered under Medical by the facility's per diem rate. It is the practice of this facility furnish a written description of rights which includes: A description of protecting person under paragraph © of this section.	t the time lity or, ible for ces that services ich the ose other ity offers be rges for resident tems and fing the lable in nose for licare or to legal ption of nal funds,		

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STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY
		185178	B. WII	NG _		07/1	5/2010
NAME OF PROVIDE		H CARE CENTER		4	REET ADDRESS, CITY, STATE, ZIP CODE 200 BROWNS LANE .OUISVILLE, KY 40220		
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	** *	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
The spect relate proces requiproving concorned include policing applied. The finame physion of the second construction of the sec	ified in subparted to maintainicatures regarding rements include written information, formulate arches a written des to impleme cable State law facility must information, cants for admission about his refunds for information, cants for admission about his refunds for benefits. REQUIREMENT on interview mined the facility for sided resident refunds for sided resident refused for purification formulation are and facility for sided resident refused for sided resident refused for sided resident refused for refused facility formulations are facility formulations are sidents wished the facility formulations are sidents wished facility for sidents wished facility	mply with the requirements I of part 489 of this chapter and written policies and and advance directives. These be provisions to inform and armation to all adult residents at to accept or refuse medical and at the individual's and advance directive. This ascription of the facility's and advance directives and	F	156	A description of the requirement procedures for establishing eligif for Medicaid, including the right request an assessment under sect 1924© which determines the ext couple's non-exempt resources at time of institutionalization and at to the community spouse an equivalence of resources which cannot considered available for payment the cost of the institutionalized simedical care in his or her process spending down to Medicaid eligiliary levels. The facility continues to post nated addresses and telephone number pertinent State client advocacy graces such as the State survey and cert agency, the State licensure office State ombudsman program, the protection and advocacy network the Medicaid fraud control unit; statement that the resident may a complaint with the State survey certification agency concerning abuse, neglect, and misappropriates resident property in the facility, non-compliance with the advance directives requirements. The facility continues to comply the requirements specified in subpart 489 of this chapter related to maintaining written policies and procedures regarding advance	bility to tion tent of a at the attributes nitable be t toward pouse's s of ibility mes, s of all groups ification e, the k, and and a and resident attion of and be with opart1 of	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		IPLE CONSTRUCTION	(X3) DATE S	
			A. BU B. WII		103		
		185178	D. VVII	4G		07/1	5/2010
	PROVIDER OR SUPPLIER OPHER EAST HEALTI	I CARE CENTER		4	REET ADDRESS, CITY, STATE, ZIP CODE 200 BROWNS LANE OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	The findings included Review revealed the for informing reside an Advance Directive treatment and to do in the clinical records 1. Review of the clinical revealed the resider on 06/25/10. The faminimum Data Set (07/02/10 which revealed informed of the right treatment on admissions. There we record of whether on executed an Advance informed of the right treatment on admissions. Interview with Resider Poirective; however, the right to accept on 06/28/10. The family assessment or resident was able to There was no evider indicate whether or ran Advanced Directive; however indicate whether or ran Advanced Directive; however, it is a session of the clinicate whether or ran Advanced Directive indicate whether or ran Advanced Directive indicate with Resider revealed the resident revealed revealed the resident revealed the resident revealed revealed the resident revealed revealed the resident revealed reve	e facility did not have a policy nts of their right to formulate we and to accept or refuse cument the resident's wishes on admission. Inical record for Resident #5 at was admitted to the facility acility completed an admission MDS) assessment on waled the resident had difficulty ecisions only in new as no evidence in the clinical ont the resident had ced Directive and been to accept or refuse medical	F	156	directives. These requirements provisions to inform and provisions to inform and provision formation to all adult resident concerning the right to accept of medical or surgical treatment at individual's option, formulate a advance directive. This include written description of the facility policies to implement advance and applicable State law. The facility will continue to information of the name, specialty, of contacting the physician respect for his or her care. It is the practice of this facility to prominently display in the facility written information, and provid residents and applicants for admoral and written information about apply for an use Medicare and Medicaid benefits, and how to refunds for previous payments of by such benefits.	de written ts or refuse nd, at the an es a ty's directives form each and way consible to ity e to nission out how d receive	



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		185178	B. WII	NG _	W408	07/1	5/2010
	PROVIDER OR SUPPLIER OPHER EAST HEALTI	H CARE CENTER	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 1200 BROWNS LANE OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	the right to accept of 3. Review of the clir revealed the resider on 04/22/10 with dia Left Pelvic Fracture Hypothyroidism. The clinical record to independent had execut been informed of the medical treatment of the right to accept or if residents had eon admission to the Interview with the Scotial Services Assistent had fourteen (14 complete this assess the had fourteen (14 complete this assess the resident on 07/16/09 with dia Dementia and Respevidence in the clinical refuse medical trees. Review of the clinical refuse medical trees.	price refuse medical treatment. Inical record for Resident #12 Int was admitted to the facility agnoses to include status post, B12 Deficiency, and here was no evidence in the licate whether or not the licate whether or not the licate whether or refuse or eright to accept or refuse on admission. Idmissions Director on revealed she did not for not residents were informed at or refuse medical treatment executed Advanced Directives facility. Inical Services Director on revealed she did document when she completed the essment; however, she stated an incal record for Resident #15 at was admitted to the facility gnoses to include Sepsis, iratory Failure. There was no cal record to indicate whether and executed an Advance formed of the right to accept eatment on admission.	F	156		ents by the #5, 12, rom the expired at at #18 /10 and 0; 10 and the made on itted to amented e ted a which ing. It is afform sentative and aning of refuse d with esidents ected by All be	Janle

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		PLE CONSTRUCTION	(X3) DATE S COMPLE	
		185178	B. WIN	IG		07/1	5/2010
	PROVIDER OR SUPPLIER OPHER EAST HEALT	H CARE CENTER		42	EET ADDRESS, CITY, STATE, ZIP CODE 00 BROWNS LANE DUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 203 SS=D	There was no evide indicate whether or an Advance directive to accept or refuse admission. 6. Review of the clir revealed the resider on 02/16/10 and expose exidence in the constant of the clir revealed the resider on 05/10/10 and disparation of the clir revealed the resider on 05/10/10 and disparation of the resider on 05/10/10 and disparation of the right treatment on admiss 483.12(a)(4)-(6) NO BEFORE TRANSFE Before a facility transport of the resident of the resident of the reasons for the reasons for the reasons in the residude in the notice paragraph (a)(6) of the reasons in the residude in the notice paragraph (a)(6) of the resident of the reasons of	and Acute Respiratory Failure. Ince in the clinical record to not the resident had executed the or been informed of the right medical treatment on Inical record for Resident #23 In the was admitted to the facility bried on 05/15/10. There was clinical record to indicate the esident had executed an or informed of the right to redical treatment on admission. Inical record for Resident #24 In the was admitted to the facility charged to an acute care There was no evidence in Indicate whether or not the the dan Advanced Directive or the to accept or refuse medical sion. TICE REQUIREMENTS TICE REQUIREMENTS TICE REQUIREMENTS TICE REQUIREMENTS TICE REQUIREMENTS THE RECORD THE REC	F 1	03	What measures will be put into or what systemic changes you make to ensure that the deficie practice does not recur – The facility of the initial and DNR policies with the initial nursing assessment process. Up admission, the admitting nurse were view with the patient the facility policies on Limited Treatment a DNR. Once reviewed, the patient his/her designated representative attest to the wishes of the patient sign that they have received a contract the policy, understand their right have designated their wishes. To signed acknowledgement will the placed in the resident medical resunder the DNR tab. How does the facility plan to not its performance to ensure that solutions are sustained – The facility of the process and we report any deviations to the process and we report any deviations to the process weekly basis to the Director of Nursing will represented.	will ent Cacility cment al on vill ty nd nt or e will t and opy of ts and Che en be ecord acility monitor vill tess on a Nursing. oort any QAA	
	this section, the notice	ed in paragraph (a)(5)(ii) of ce of transfer or discharge graph (a)(4) of this section					



OFFICE OF INSPENIOR GLOCKAL Dividion of he with Care Paulines and Services

DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		185178	B. WII			07/1	5/2010
	PROVIDER OR SUPPLIER OPHER EAST HEALTI	H CARE CENTER	L	4:	EET ADDRESS, CITY, STATE, ZIP CODE 200 BROWNS LANE OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 203	must be made by the before the resident. Notice may be made before transfer or dindividuals in the faunder (a)(2)(iv) of the health improves suffimmediate transfer (a)(2)(i) of this section discharge is required medical needs, und section; or a resider facility for 30 days. The written notice is this section must in or discharge; the local transferred or discharge; the efficient has the riging State; the name, and of the State long tennursing facility resident has the riging State; the name, and of the State long tennursing facility resides the Developmental of Rights Act; and for who are mentally ill, telephone number of the protection and a dindividuals establish Advocacy for Mental and the discharge of the protection and a dindividuals establish Advocacy for Mental and the protection and a dindividuals establish Advocacy for Mental and the protection and a dindividuals establish Advocacy for Mental and the protection and a dindividuals establish Advocacy for Mental and the protection and a dindividuals establish Advocacy for Mental and the protection and a dindividuals establish Advocacy for Mental and the protection and a dindividuals establish Advocacy for Mental and the protection and a dindividuals establish Advocacy for Mental and the protection and a dindividuals establish Advocacy for Mental and the protection	ge 6 ne facility at least 30 days is transferred or discharged. e as soon as practicable ischarge when the health of cility would be endangered his section; the resident's fficiently to allow a more or discharge, under paragraph on; an immediate transfer or ad by the resident's urgent er paragraph (a)(2)(ii) of this has not resided in the pecified in paragraph (a)(4) of clude the reason for transfer fective date of transfer or ion to which the resident is arged; a statement that the latt to appeal the action to the latress and telephone number of care ombudsman; for lents with developmental ing address and telephone cy responsible for the locacy of developmentally established under Part C of Disabilities Assistance and Bill or nursing facility residents the mailing address and of the agency responsible for idvocacy of mentally ill ned under the Protection and ally Ill Individuals Act. IT is not met as evidenced	F	203	It continues to be the practice of facility, prior to transfer, to notif resident and, if known, a family or legal representative of the rest the transfer or discharge and the for the move in writing and in a language and manner they unde record the reason's in the reside clinical record; and include in the items described in paragraph of this section. Except when specified in paragraph of this section. Except when specified in paragraph of this section. Except when specified in paragraph (a)(5)(ii) of this section, the not transfer or discharge required urparagraph (a)(4) of this section made by the facility at least 30 before the resident is transferred discharged. Notice is made as soon as practical before transfer or discharge which health of individuals in the facility would be endangered under (a) this section; the resident's healting improves sufficiently to allow a immediate transfer or discharge paragraph (a)(2)(i) of this section mediate transfer or discharge required by the resident's urger medical needs, under paragraph (a)(2)(ii) of this section; or a rehas not resided in the facility for days	ry the member sident of reasons rstand; ent's ne notice h (a)(6) raph ice of nder must be days d or cicable en the lity (2)(iv) of the a more e, under on; an e is nt h esident	

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AND L DAN	O GORREGION	IDENTI IOATION NOMBER.	A. BUI	LDIN	G		
		185178	B. WIN	1G _		07/1	5/2010
	PROVIDER OR SUPPLIER OPHER EAST HEALT	H CARE CENTER		4:	REET ADDRESS, CITY, STATE, ZIP CODE 200 BROWNS LANE OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 203	Based on interview determined the faci discharge to one (1 residents, (Resident regulatory guideline to provide a notice twenty-five (25) sar and Resident #24), an acute care facility. The findings include Record review for Format of discharge from the discharge as the faresident's needs. For the facility (the brain-injective in a skilled the facility could me another unit of the facility as with the admissions the facility (outside was told there was long-term care bed Telephone interview o7/15/10 at 5:00pm offered Resident #2 outside of the brain letter was sent.	and record review it was lity provided a letter of) of twenty-five (25) sampled at #25), which did not meet es. In addition the facility failed of transfer to two (2) of impled residents, (Resident #23 when they were transferred to ty. e: Resident #25 revealed a letter the facility with the reason for cility could not meet the Resident #25 did not meet dent on a specific unit of the fury unit) but did meet the bed in the facility. Therefore, eet the resident's needs on facility. esident's father on 07/15/10 at e is the responsible party for the received the discharge letter a whole. He stated he inquired is office about another bed in of the brain-injury unit) and a two-year waiting period for a	F 2	203	The written notice specified in paragraph (a)(4) of this section include the reason for transfer or discharge; the location to which resident is transferred or dischars statement that the resident has the to appeal the action to the States name, address and telephone nuther State long term care ombude nursing facility residents with developmental disabilities, the raddress and telephone number of agency responsible for the protect and advocacy of developmental disabled individuals established Part C of the Developmental Diach Assistance and Bill of Rights A for nursing facility residents when mentally ill, the mailing address telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection Advocacy for Mentally Ill Individuals accomplished for those residents found to have been affected by deficient practice — The facility withdrew notice of discharge for patient on 7/6/10. Patient has a voluntarily discharged to anoth on 7/30/10.	the the right; the mber of sman; for mailing of the ection lly lunder isabilities act; and no are ss and yend duals in and viduals. I be ents by the exy or this since	

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		185178	B. WIN	1G		07/1	5/2010
	PROVIDER OR SUPPLIER	TH CARE CENTER		42	REET ADDRESS, CITY, STATE, ZIP CODE 200 BROWNS LANE OUISVILLE, KY 40220	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 203	#25 another bed in letter was sent to food Administrator did revision. Review of the clinic revealed the reside on 02/16/10 with desire and a statement of Pneuron The resident was to 04/15/10 for treatment of Pneuron The resident was to 04/15/10 for treatment of Pneuron The resident was to 04/15/10 for treatment of Pneuron The resident returned to 04/29/10 the resident resident and an another facility on 04/30 revidence the facility the family with a nother reason for the date of the transfer which the resident and a statement the appeal and how to Review of the clinic revealed the reside on 05/28/10 with desident, Stage IV	the facility after the discharge Resident #25's father, but the not have that evidence in cal record for Resident #23 and was admitted to the facility iagnoses of Depression, Diabetes, and Stage IV in the Heel. Review of the summaries revealed the ferred to a hospital for monia on 03/10/10 and fillty on 03/18/10. On 04/04/10, and to a hospital for treatment and a low potassium level, and a low potassium level, and to the facility on 04/09/10. ransferred to a hospital on ment of an infection. The context of the facility on 04/16/10. On the facility on 04/16/10, on the facility on 04/16/10. On the facility on 04/16/10, on the facility on 04/16/10, on the facility on 04/16/10. On the facility on 04/16/10, on the facility on 04/16/10, on the facility on 04/16/10, on the facility on 04/16/10. On the facility on 04/16/10, on the facility on 04/16/10, on the facility on 04/16/10, on the facility on 04/16/10. On the facility on 04/16/10, on 04/10/10, o	F2	203	How will you identify other rhaving the potential to be affethe same deficient practice? residents have the potential to deffected by this deficient practice. What measures will be put in or what systemic changes will make to ensure that the defic practice does not recur — Any letters of discharge will contain specifics as to the reason of intinvoluntary discharge for the ir resident. In addition, all future will contain all required inform accordance with regulatory guidence with regulatory guidence to ensure the solutions are sustained — All fletters of discharge will be revithe Administrator or Assistant Administrator ensure all require regulatory guidelines have been prior to delivery to the patient of identified representative. All lewill be reviewed quarterly by the QAA Committee.	ected by All be ice. Ato place I you ient future detailed ended dividual eletters nation in delines. monitor at future ewed by ed n met or his/her etters sent	Narlo

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DEPARTMENT OF HEALTH AND HU! 1 SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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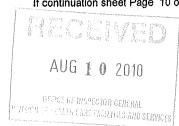
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		185178	B. WIN	1G		07/1	5/2010
	PROVIDER OR SUPPLIER OPHER EAST HEALTI	H CARE CENTER	1	4:	REET ADDRESS, CITY, STATE, ZIP CODE 200 BROWNS LANE OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 205 SS=E	was discharged to a was no evidence to the resident and far transfer/discharge. Interview with the S the Admissions Dire revealed the facility families with a notic stated transfer and during admission ar this notice to reside 483.12(b)(1)&(2) NO POLICY BEFORE/U Before a nursing facinformation to the reor legal representat of the bed-hold polic during which the resand resume residenthe nursing facility's periods, which must (b)(3) of this section return. At the time of transfe hospitalization or the facility must provide member or legal representation or the facility must provide member or legal representation or the facility must provide member or legal representation or the facility must provide member or legal representation or the facility must provide member or legal representation or the facility must provide member or legal representation or the facility must provide member or legal representation or the facility must provide member or legal representation or the facility must provide member or legal representation or the facility must provide member or legal representation or the facility must provide member or legal representation.	a hospital on 06/05/10. There indicate the facility provided mily with a notice of ocial Services Director and ector on 07/15/10 at 3:50pm did not provide residents and e of transfer/discharge. She discharge were reviewed and the facility had not provided and the facility had not provided and families in the past. OTICE OF BED-HOLD JPON TRANSFR cility transfers a resident to a resident to go on therapeutic acility must provide written esident and a family member ive that specifies the duration by under the State plan, if any, sident is permitted to return ace in the nursing facility, and policies regarding bed-hold to be consistent with paragraph of permitting a resident to	F 2		It continues to be the practice of facility to ensure that before a magnetic facility transfers a resident to a hor allows a resident to go on the leave, the nursing facility must puritten information to the resident family member or legal represent that specifies the duration of the hold policy under the State pland during which the resident is perreturn and resume residence in the nursing facility and the nursing policies regarding bed-hold periodicies regard	ursing hospital rapeutic provide ent and a htative bed- , if any, mitted to he facility's ods, haragraph , a lent for ave, a the r legal hich l-hold (b)(1) of be nts y the sident	8/27/10

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Event ID: WR2H11

Facility ID: 100201

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DEPARTMENT OF HEALTH AND HUN N SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

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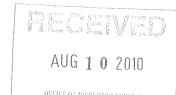
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPLE	
		185178	B. WING		07/1	5/2010
	PROVIDER OR SUPPLIER OPHER EAST HEALT	H CARE CENTER	S	TREET ADDRESS, CITY, STATE, ZIP C 4200 BROWNS LANE LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	determined the faci the facility's bed-hot twenty-five (25) san transfer to an acute #21, #23, and #24 version facility's bed hold pot an acute care facility. The findings included A review of the facilistated that if a resid for more than twent or the legal represe arrangements to parpatient's departure, be signed. The polity residents and familiar policy at the time of hospital or beginning. Review of the clinicar evealed an admission diagnoses to include Renal Failure, and Stringh. Further review #7 did not reveal and reservation form was bed-hold policy was resident's responsible was transferred to a Review of the clinicar evealed an admission diagnoses to include Hypertension, and A record for Resident's evidence that a bed	lity failed to provide a copy of a policy to four (4) of applied residents at the time of care hospital. Residents #7, were not given a copy of the olicy at the time of transfer to y. It is bed hold policy, undated, ent is away from the facility y-four (24) hours, the patient antative must make y for a bed-hold prior to the A bed reservation form must be yellowed by the bed-hold transfer to an acute care go a therapeutic leave. If record for Resident #7 for date of 05/18/10 with the Abscess Left Leg, Acute and Cell Cancer of the Left bew of the record for Resident y evidence that a bed so signed or that a copy of the given to the resident or the le party when the resident macute care facility. If record for Resident #21 on date of 07/23/09 with	F 20	How will you identify oth having the potential to be the same deficient practice residents have the potential effected by this deficient process. What measures will be processed on the practice does not recurpractice; each resident is infacility bed hold policy up. The facility has now institt copy of the policy which we to any resident transferring facility or those going on a leave of absence. This for presented to the patient up facility by the nurse arrang or transfer. The nurse will a copy of the form that is a copy will become part of the record.	e affected by ce - All al to be bractice. ut into place s will you deficient As per our informed of the con admission. uted a written will be given g out of the a therapeutic m will be on exiting the ging the leave sign and date given and that	

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Event ID: WR2H11

Facility ID: 100201

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OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES

DEPARTMENT OF HEALTH AND HUN N SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

PRINTED: 07/28/2010 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE S COMPLE	
		185178	B. WIN	1G_		07/1	5/2010
	PROVIDER OR SUPPLIER	H CARE CENTER		4:	REET ADDRESS, CITY, STATE, ZIP CODE 200 BROWNS LANE OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 205	the resident or the when the resident of care facility. Review of the clinic revealed the reside on 02/16/10 with dispailure To Thrive, I Pressure Ulcers on hospital discharge resident was transfor treatment of Progreturned to the facilithe resident was set treatment of syncopy. The resident was treatment of syncopy. The resident was treatment of o4/15/1 infection. The resident was treatment on 04/15/1 infection. The resident was treatment of syncopy. The resident was return. The resident was return. Review of the clinic evidence the facility the family with copie at the time of the tracare needs. Review of the clinic revealed the resident on 05/28/10 with dia Accident, Stage IV Sacrum, Diabetes, was discharged to a 06/05/10. There was facility provided the	resident's responsible party was transferred to an acute all record for Resident #23 nt was admitted to the facility agnoses of Depression, Diabetes, and Stage IV the Heel. Review of the summaries revealed the erred to an acute care hospital eumonia on 03/10/10 and ity on 03/18/10. On 04/04/10, and to an acute care hospital for be and severe hypokalemia. The period of the facility on 04/09/10. It is an acute to the facility on 08/10 the resident was sent to ital for treatment of an unknown and the facility on 04/30/10. It is an acute care to the facility on 04/30/10. It is an acute care to the facility on 04/30/10. It is an acute care and severe hypokalemia. The period of the facility on 04/30/10. It is an acute care hospital for acute all record for Resident #24 and the facility bedhold policy ansfers to a hospital for acute all record for Resident #24 and the same acute care hospital on as no evidence to indicate the resident and family with a bedhold policy at the time of	F2	205	How does the facility plan to its performance to ensure that solutions are sustained?— The of Nursing or her designee will any transfers out to acute care of therapeutic leaves every busine ensure that the proper process if followed for patient notification bed hold policy. Those noted to of compliance will be addresse immediately by phone and writh notification will be sent to the his/her identified representative Deviations to this process will during nursing clinical rounds findings will be reported to the QAA Committee on a monthly	t Director review or less day to has been nof the cobe out ad tten patient or e by mail. be noted and all e facility	8/27/10

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PRINTED: 07/28/2010 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE S	
		185178	B. WIN	1G _		07/1	5/2010
NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER				4:	EET ADDRESS, CITY, STATE, ZIP CODE 200 BROWNS LANE OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241 SS=D	transfer. Interview with the Sthe Admissions Dire revealed the facility families with a copy when transferred to stated residents we policy on admission 483.15(a) DIGNITY INDIVIDUALITY The facility must promanner and in an eenhances each resifull recognition of him to be consumed to the facione unit (the braining was usual and cust enhance each residunsampled resident assigned to have nithours of 6:00pm an all of them to be consumented six (6) be bathed on the nigmemorandum dated manager revealed to the consumer revealed to the state of the st	ocial Services Director and ector on 07/15/10 at 3:50pm did not provide residents and of the facility's bedhold policy an acute care facility. They re informed of the bedhold AND RESPECT OF comote care for residents in a nvironment that maintains or dent's dignity and respect in s or her individuality. IT is not met as evidenced and record review it was lity failed to bathe residents on njury unit) of the facility as comary throughout the facility to ent's dignity. Eight (8) is on the brain-injury unit were ght shift showers between the d 6:00am with the potential for mpleted after 11:00pm.		205	It continues to be the practice of facility to promote care for resident manner and in an environment the maintains or enhances each resident and respect in full recognists or her individuality. What corrective action(s) will accomplished for those resident found to have been affected by deficient practice? — A review residents who are listed to receive showers on the evening shift was performed and the schedule reviensure the showers are completed p.m. as is the facility protocol. How will you identify other residents to be affected by deficient practice? —	lents in a hat dent's nition of be nts / the of the 8 we as ised to ed by 10 sidents cted by	8/27/10

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DEPARTMENT OF HEALTH AND HUN N SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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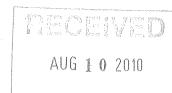
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185178	B. WING	3	07/1	15/2010	
NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP C 4200 BROWNS LANE LOUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 241	showers. This men showers should not medication pass tim primarily before 12: was a follow-up me Unit Director which staff to attempt to h completed by 11:00 schedules for the or residents assigned. Interview with the bio 07/15/10 at 10:45ar the residents being by the unit manage written the follow-up regarding having the 11:00pm. The Unit reason eight (8) resumedical diagnoses when they were unaware acceptable to bathe 11:00pm regardless pre-injury. Interview with LPN revealed the earlies unit residents would start at 7:30am and for some of these reafter 11:00pm. Interview with the Drevealed residents cont bathed on night	norandum also revealed these be completed during nes which were to occur 00midnight. However, there morandum on 07/12/10 by the revealed a request for the ave the night shift showers of the period of the bathing ther facility units revealed no to night shift showers. Tain-injury Unit Director on the revealed she was aware of assigned night shift showers and she stated she had to memorandum of 07/12/10 the see showers completed by Director also revealed the idents of this unit were nift showers was due to their of brain-injury. She stated why admitted with the injury, of night or day, and it made it them on the night shift after to fine their personal routine of their personal routine. #5 on 07/15/10 at 2:10pm the therapy for the brain-injury be social dining which would so she felt it would be okay esidents to have a shower. ON on 07/15/10 at 11:00am on the other facility units are shift in order to preserve their of this or her own individuality.	F 24	What measures will be por what systemic changes make to ensure that the opractice does not recur? members on Pathways and Skills (brain injury) unit win-service regarding the reshower schedule and that will be completed by 10:0 How does the facility pla performance to ensure the are sustained? — A month forwarded to the Quality A Committee for review to ecompliance with the process.	ractice. ut into place s will you deficient — All staff I the Life rill receive an vised evening the showers 0 p.m. n to monitor its nat solutions ally report will be Assurance ensure		

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OFFICE OF INSPECTOR GENERAL DIVISION OF MEACH CAPS FACILITIES AND SERVICES

DEPARTMENT OF HEALTH AND HU(N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2010 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185178	B. WIN	IG		07/1	5/2010
NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER ON A ID. SUMMARY STATEMENT OF DEFICIENCIES				42	EET ADDRESS, CITY, STATE, ZIP CODE 200 BROWNS LANE OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 248 SS=D	of activities designed the comprehensive the physical, mental of each resident. This REQUIREMED by: Based on observation review, it was deterprovide a program twenty-five (25) sawith the Comprehensive As interests and physical well-being of the resident #17 in accomprehensive As interests and physical well-being of the resident #17 in accomprehensive As interests and physical well-being of the resident #17 in accomprehensive As interests and physical well-being of the resident #17 in accomprehensive As interests and physical at "multi-faceted as a therapeutic envirologitive, physical, stimulation." Resident #17 was a 3:45pm on 07/14/14 and sitting in a whee closed. The only vibedside included two sock monkey. The	ovide for an ongoing program ed to meet, in accordance with assessment, the interests and all, and psychosocial well-being of activities for one (1) of activities for one (1) of activities for one (1) of activities for one activities for one of activities for one of activities for one of activities for one of activities for ordance with the activity program of activities for ordance with the activity program of activity program of activity program of activity program which creates on the color of activity program activity program which creates on the color of activity program activity program which creates on the color of activity program activity program which creates on the color of activity program activity prog	F 2	248	The facility will continue to provan ongoing program of activities designed to meet, in accordance comprehensive assessment, the in and the physical, mental, and psychosocial well-being of each resident. What corrective action(s) will accomplished for those resider found to have been affected by deficient practice? — A re-asse was completed for Resident #17 on the patient's expressed interes has been provided with a radio/O player and personal player with room for times when resident cherelax in room. The staff will invassist the resident to out of room activities weekly. The Ky. Office Blind has been contacted and we assessing for different services, including talking books. How will you identify other rehaving the potential to be affected by this deficient practice?—residents have the potential to be effected by this deficient practice.	be nts the ssment Based sts, she CD CD's in nooses to ite and n group te for the ill be sidents cted by All e	8/27/10
	The findings included Review of the facility dated, 01/07/05, strips a "multi-faceted at the appeutic environce ognitive, physical, stimulation." Resident #17 was a 3:45pm on 07/14/19 and sitting in a whee closed. The only vibedside included two sock monkey. The silent. Resident #1	e: ty's Activity Program Policy ated that the Activity Program activity program which creates comment that promotes social, and sensory observed in his/her room at 0 dressed in a hospital gown elchair with his/her eyes sible personal items at the yo small stuffed animals and a			relax in room. The staff will invassist the resident to out of room activities weekly. The Ky. Office Blind has been contacted and with assessing for different services, including talking books. How will you identify other rehaving the potential to be affect the same deficient practice? - residents have the potential to be	ite and in group se for the ill be sidents cted by All e	



DEPARTMENT OF HEALTH AND HV \N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE S COMPL		
		185178	B. WIN	1G		07/·	15/2010	
NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER				4:	REET ADDRESS, CITY, STATE, ZIP CODE 200 BROWNS LANE OUISVILLE, KY 40220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	wheelchair at bedsi closed, and head n Resident #17 was of 11:30am on 07/15/folded in lap, and head in The room was dark television was playi 07/15/10 the reside wheelchair at bedsi waist, eyes closed, nodding downward Review of the Initial found that Resident an active and practi indicated enjoyment a regular basis and self to be a 'social p was asked if he/she resident replied, "No would be enjoyed in activities in the day/ Activity/Recreation i (talking) books, chu special events. Resident #17 was in 7/15/10 regarding pactivities. The resid when asked if he/she he/she listened to the When the resident wis passed, and what resident said, "I usua The resident indicate both Classical and Fhave a radio. The rereading material "set reading material" set of the said in the resident material "set of the said in the resident material" set of the said in the resident material "set of the said in the resident material" set of the said in the resident material "set of the said in the resident material" set of the said in the resident material "set of the said in the said in the resident material" set of the said in the sai	de, hands folded in lap, eyes odding downward to chest. observed in his/her room at 10 with eyes closed, hands ead nodding down to chest. ened, and the roommate's ng low. At 1:40pm on nt was found sitting in a de with a gait belt on his/her hands folded in lap, and head	F 2	248	What measures will be put in or what systemic changes will make to ensure that the defici practice does not recur? — In accordance with the Comprehent Activity Admission Assessment staff will continue to interview residents and establish individual personal activity interests and gruther, the staff will encourage and assist residents to participate of room group activities of interested on a daily basis. In the resident is unable to participate room group activities, the staff in room 1-1 and offer in room activities. How does the facility plan to not its performance to ensure that solutions are sustained? — Mon patient interviews will be completed and Ad Hoc Committee to be determined by the facility QAA Committee will monitor the results for compand who will make necessary recommendations for improvements.	nsive t, the new al and oals. e, invite e in out rests event a in out of will visit ctivities nonitor othly eted by ermined who oliance	Nallo	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC. ... SERVICES

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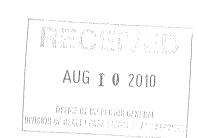
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185178	B. WIN	G	· · · · · · · · · · · · · · · · · · ·	07/	15/2010
NAME OF PROVIDER OR SUPPLIER CHRISTOPHER EAST HEALTH CARE CENTER				4200	T ADDRESS, CITY, STATE, ZIP CODE I BROWNS LANE IISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 248	of any progress. The he/she was notified Schedule. The residence it." The residence aware that live pian 07/14/10 near the Fither music was described aware that live pian 07/14/10 near the Fither music was described by the music was asked visit he/she receive from the Assistant Aresident replied, "Ye never stays long aroommate) mostly." An interview with the 1:50pm on 07/15/10 earlier with Residence of One-on-One visit resident prefers to be Assistant was advist that he/she enjoys of the piano music properties of the piano music properties in the piano music propert	ne resident was asked how regarding the Activity dent said, "I don't knowI edule in my room, but I can't ent was asked if he/she was o music was provided on florida room after lunch and cribed as some Religious with v tunes. The resident replied, would have liked that." The to describe the One-on-One dearlier today on 07/15/10 Activities Director. The eah, he was here, but he nd he was speaking to (my	F 2	48			

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DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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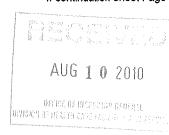
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185178	B. WII	1 G _		07/1	5/2010
	PROVIDER OR SUPPLIER OPHER EAST HEALT	H CARE CENTER	——————————————————————————————————————	4	REET ADDRESS, CITY, STATE, ZIP CODE 1200 BROWNS LANE 1.OUISVILLE, KY 40220		0/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	working on it." The resident is informed the resident is blind schedule in their rod activities are annou activity and the resident #17 enjoy: music, and would like Activity Director was not aware of the pia afternoon of 07/14/7 the resident said, "I that." 483.15(h)(2) HOUS MAINTENANCE SET The facility must promaintenance service sanitary, orderly, and This REQUIREMEN by: Based on observation determined the facility housekeeping and recessary to maintacomfortable interior. The 400 unit were in were soiled. Showe were not thoroughly the findings include Observation of the 107/14/10 at 9:00am, with brown ground-in were soiled.	Director was asked how the of scheduled activities, since and unable to read the om. The Director stated that need on each unit before the dents are encouraged to Director was told that sector considers and Religious are to have a radio. The stold that Resident #17 was no music provided on the 10 near the Florida room, and probably would have liked EKEEPING & RVICES Divide housekeeping and es necessary to maintain a dicomfortable interior. It is not met as evidenced on and interview, it was ty failed to provide naintenance services in a sanitary, orderly, and Cabinets and drawers on disrepair and linen barrels rooms had soiled areas that cleaned.	F 2	253	It is the practice of this facility the provide housekeeping and main services necessary to maintain a sanitary, orderly, and comfortabiliterior. What corrective action(s) will accomplished for those resider found to have been affected by deficient practice? — The 100 shower stretcher, 200 wing line trash barrels have been power wand cleaned. The 300 wind pape have been removed. The holes it walls in rooms 210 and 422 have repaired. The facility is currently working purchasing and plant operations remove the old cabinet doors and drawers and replace them with n furniture. Orders have been place the furniture and the facility currently working purchasing and plant operations administrator will meet with the operations director to finalize the complete the demolition of the a areas.	be nts y the wing en and vashed er signs n the e been with to d d ew ced for rently ne l plant e date to	8/27/10

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DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185178	B. WI	NG_		07/1	5/2010
	PROVIDER OR SUPPLIER OPHER EAST HEALT	H CARE CENTER		4	REET ADDRESS, CITY, STATE, ZIP CODE 200 BROWNS LANE OUISVILLE, KY 40220		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 253 F 273 SS=D	linen and trash barrand the 200 showe particles around the around the around the around the around the around the 300 win and stained paper s. There were holes in 422. Observation of the 9:20am, revealed c. closed and drawers pulls and off the tra 422, 426, 428, 431, cabinets in rooms 4425. The footboard 428 had worn stain showing through. Interview with the MO7/15/10 at 9:30am on the 400 wing we frequently; however drawers would pull the drawer pulls we indicated the facility in the future. Interview with the A 10:00am, revealed had been discussed approval for the ren Interview with the HO7/15/10 at 9:45am trash barrels were melated the nursing splace them in the sh 483.20(b)(2)(i) COM	rels in the central shower room in room had brown ground-in room had brown ground-in e outside of the lids. The area g shower room had discolored signs hanging on the walls. In the walls in room 210 and 400 wing on 07/14/10 at abinet doors that could not be a that were missing drawer ck in rooms 410, 411, 414, 427, and 425, also the 11, 414, 422, 428, 434, and also needs in rooms 426 and with the base material diaintenance Assistant on revealed the dresser drawers are put back on the track or repaired as identified. He might be renovating the area diministrator on 07/15/10 at renovation of the 400 wing drawer, there was no ovation at this time. Ousekeeping Director on revealed the soiled linen and nissed by housekeeping and staff take the barrels and nower rooms.	F	253	How will you identify other rehaving the potential to be affethe same deficient practice? residents have the potential to be effected by this deficient practice. What measures will be put into or what systemic changes will make to ensure that the deficipractice does not recur? — Sinthe final phase of replacement of millwork within the facility, fut assessments of patient room fur will be completed by the mainted director, under the supervision assistant administrator in replacement. How does the facility plan to its performance to ensure that solutions are sustained? — The Committee, an Ad Hoc Committee, winclude patient furniture assessing part of their monthly rounds. Find the presented to the full Coon a monthly basis.	cted by All e ce. to place you ent ce this is of dated cure miture enance of the cement of tg monitor it e Safety ttee of cill ments as Findings	

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DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2010 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		185178	B. WING		07/15/2010
	PROVIDER OR SUPPLIER DPHER EAST HEALT	H CARE CENTER		REET ADDRESS, CITY, STATE, ZIP CODE 4200 BROWNS LANE LOUISVILLE, KY 40220	0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTION
F 273	A facility must condassessment of a reafter admission, exthere is no significate physical or mental this section, "readmission or facility following a thospitalization or facility following at thospitalization or facility following a thospitalization or facility following a thospitalization or facility following a thospitalization or facility following at thospitalization or facility following the facility following as twenty-five (25) sai within fourteen day admission Minimur was not completed	duct a comprehensive esident within 14 calendar days cluding readmissions in which ant change in the resident's condition. (For purposes of mission" means a return to the emporary absence for or therapeutic leave.) NT is not met as evidenced eview and interview, it was sility failed to conduct a sessment for one (1) of mpled residents (Resident #5) is of admission. Resident #5's in Data Set assessment (MDS) until eighteen days after	F 273	It is the practice of this facility conduct a comprehensive asses a resident within 14 calendar dadmission, excluding readmiss which there is no significant characteristic the resident's physical or mention condition. (For purposes of this "readmission" means a return the facility following a temporary for hospitalization or for the rapleave.) What corrective action(s) will accomplished for those resident accomplished for those resident deficient practice? — The administration of the resident practice? — The administration of the resid	ssment of ays after ions in nange in al is section, to the absence beutic Il be ents by the mission
	at 4:10pm revealed Resident Assessme Manual as the facili comprehensive ass revealed admission completed within for Review of the clinic 07/13/10 revealed to admission MDS ass Interview with the M 3:00pm, revealed to	Director of Nursing on 07/15/10 I the facility utilized the ent Instrument (RAI) 2.0 Ity's policy on completing ressments. The policy MDS assessments would be urteen days of admission. al record for Resident #5 on here was no evidence of an resessment.		How will you identify other is having the potential to be aff the same deficient practice? residents have the potential to effected by this deficient pract. What measures will be put in or what systemic changes will make to ensure that the deficient practice does not recur? – A of MDS assessments will be only the MDS Coordinator and to the IDT each Monday accounts to the ARD, type of assessment,	Tected by - All be cice. Into place Il you cient schedule completed circulated

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